USAID|Central America Capacity Project

Strenghtening the quality of care and improving the quality of life of people living with HIV and other vulnerable populations

Cooperative Agreement No. AID-596-A-00-09-00106-00

Final Report Project Year III
(October 2011 to September 2012)

Guatemala, October 15, 2012

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Annexes

ACRONYMS/ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ANOVA	Analysis of variance
AOTR	Agreement Officer's Technical Representative
ART	Antiretroviral treatment
ASOVIHSIDA	Asociación Costarricense of Personas Viviendo con VIH-SIDA
BFLA	Belize Family Life Association
CBO	Civil based Organization
CDC	Control Disease Center
CENDEIS	Centro of Desarrollo Estratégico e Información en Salud and Seguridad Social
CoC	Continuum of Care
CODESIDA	Coordinadora Departamental de la Lucha contra el SIDA
COMUREVIH-D	Comisión Multisectorial of Respuesta al VIH en Desamparados
CRSSI	Costa Rican Social Security Institute
CUM	Centro Universitario Metropolitano
FBO	Faith based Organization
FYII	Fiscal Year II
GD	General Director
GGP	Genesis Group of Panama
GO	Governmental Organization
HIV	Human immunodeficiency virus
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources for Health Information System
ID	Identification Document
IEPROES	Instituto Especializado of Educación Superior of Profesionales de Salud de El Salvador
iHRIS	Human Resources Information Software System
IT	Information technology
LEAD	**L**eadership and Advocacy **E**xpand country leadership investments **A**lign our workforce and business systems **D**evelop our resource base
LFP	Learning for Performance
MARPS	Most at risk populations
MOE	Ministry of Education
MOH	Ministry of Health
NAC	National AIDS Commission (Belize)
NAP	National AIDS Programme
NC	North Carolina
NDACC	National Drug Abuse Control Council
NGO	Non-governmental Organizations

NIT	Taxation ID Number
OPQ	Optimizing Performance for Quality
PASMO	Pan American Social Marketing Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PI	Performance Improvement
PLH	People Living with HIV
PMP	Performance Monitoring Plan
PROBIDSIDA	Fundación Pro-Bienestar and Dignidad of las Personas Afectadas por el VIH/Sida
REDCA+	Regional Network of PLH+
SAT	National Taxation Authority
SIGSA	Guatemala Health Management Information System
SM&E	Supervision, Monitoring and Evaluation
SMS	Short messaging service
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
URC	University Research Corp., LLC
USAID	United States Agency for International Development
VCT	Voluntary Counseling Test
VPN	Virtual Private Network
WHO/PAHO	World Health Organization/Pan American Health Organization

EXECUTIVE SUMMARY

The Project continued implementation in the third project year (October 2011 – September 2012) in accordance with the work and monitoring and evaluation plans. The country technical teams accompanied the Ministries of Health (MOH) and Social Security Institute (SSI) counterparts as well as other governmental and non-governmental organizations and civil society groups for the continuity of the application of the key service strategies for the health services, universities and community networks: Optimizing Performance for Quality (OPQ); Learning for Performance (LFP); and the Continuum of Care (CoC) for HIV. In spite of the fact that this was the third project year, policy dialogue with the Ministries of Health continues unabated due to changes of the political and technical authorities. The most drastic changes occurred in Guatemala where there has been a revolving door of central and local authorities since the beginning of the calendar year. This situation has had repercussions in the programming of activities with the local and regional offices, redoubling activities during the past quarter to achieve project goals. Other external obstacles includes elections in Belize and El Salvador, a dengue alert in El Salvador, labor and student strikes in Panama, and an earthquake in Costa Rica.

In relation to OPQ, the Project measured 57 health facilities, 106% of the annual target. Of those measurements, 63% (36) corresponded to a third measurement round, 35% (20) to a second round measurement and one initial baseline measurement. The San Juan de Dios Hospital in Costa Rica postponed its measurement to the following Project year and Guatemala added an additional hospital at the request of the MOH, which executed its baseline measurement during the year.

The average overall performance score continued its growth trend as compared to the previous measurement during the year in all five project countries (Figure 1.1). All hospitals have a gap-closing plan and received at least two follow up visits during the Project year. It is important to note that the OPQ methodology is being appropriated in all countries of which four (Guatemala, El Salvador, Costa Rica and Panama) have an institutionalization plan.

The Project strengthens the functioning of five CoC networks, one in each country. All have a baseline measurement and are in the performance gap-closing phase. Among activities completed are: the development of a strategic plan; dissemination and use of standardized protocols; treatment guides and information materials; and the definition and development of instruments for a referral/counter-referral system to ensure continuity of care and services for people living with HIV.

The Project reached 120% (1991/1655) of its annual target for competency-based in-service training for health workers. The number of persons receiving pre-service training reached 107% of the annual target (781/640). Furthermore, the countries now have five university-level HIV curricula that have been implemented after training local faculty in the methodology and contents. The project also initiated a successful mLearning trial among university students in the VCT courses in Guatemala and El Salvador to assess the potential for mobile telephone technology to improve retention of course information.

The USAID|Central America Capacity Project has signed a Memorandum of Understanding (MOU) with the Directorate of Human Resources in El Salvador to implement a human resources information system using the IntraHealth developed iHRIS software platform.

The week of September 17, IntraHealth Headquarters and Project regional office experts conducted an iHRIS implementation workshop in San Salvador (also attended by HR and IT personnel from Guatemala). The training focused on transferring the capacity to the national team to make the needed modifications to the system. The result was the formation of a developer's team to install iHRIS on the MOH network servers to make the changes specified by the human resources division to modify the database according to their needs. They also initiated a Latin-American-Caribbean regional development team network (https://launchpad.net/~ihris-lac) that will be key to the transfer of capabilities to manage the iHRIS system to regional counterparts.

The institutionalization of OPQ made notable progress during the past year with Costa Rica, El Salvador, Guatemala and Panama all taking concrete steps to formally adopt the methodology. Furthermore, OPQ is well positioned and implemented in four of the five health areas in Belize and the OPQ tools are being used by the central level Accreditation Unit to monitor all hospital laboratories. The measurement databases for all 58 health facilities are completed and the training for each of the facilities to transfer the database and use it will take place during the Project Year IV's second and third quarters.

IntraHealth has begun creating a guide to integrate a gender and human rights focus into the USAID|Capacity Project in Central America. The guide is intended as a reference for: the Project's technical team; hospitals; health centers; universities; and networks within the region on how to integrate and uphold a gender and human rights focus and standards within their institutions, curricula and projects.

The total amount expended in Year 3 was US$491,262 plus pending provisional expenses of US$108,343, for a total of US$599,605. Total cost share is $1,077,235, which is 103% of the EOP target in the Cooperative Agreement.

I. REGIONAL RESULTS

The Project contributes to the following five results during the past year (October 2011 – September 2012) in the Project countries of Belize, Costa Rica, El Salvador, Guatemala and Panama.

- Result 1: Performance Improvement (PI) and Continuum of Care (CoC).
- Result 2: In-service training for human resources for health (HRH) and training for participants in the networks (governmental NGOs and Civil Society)
- Result 3: Strengthening of pre-service training for treatment providers, with updated information on HIV/AIDS and increase access to early diagnosis through voluntary counseling and testing.
- Result 4: Development and use of information technologies for distance learning and a training database.
- Result 5: Systematization and institutionalization of PI.

Detailed results are showcased in the Performance Monitoring Plan (PMP), Annex 2. Table No. 1 shows the hospitals applying OPQ by country and project/fiscal year when they initiated the activity. During Year III the Malacatan Hospital in Guatemala was included at the request of the Ministry of Health (MOH) raising the total of participating facilities to 58, four more than the original target. The distribution of participating health facilities by country is: Belize - 7; Costa Rica - 10; El Salvador -12, Guatemala - 15; and 14 in Panama.

Table 1. Health facilities implementing OPQ by country and year of initiation as of September 2012

USAID| Capacity Central America Project Year	Belize	Costa Rica	El Salvador	Guatemala	Panama
37 participating, facilities in year I (Oct 2009- Sep 2010)	1. Karl Heussner Memorial 2. Orange Walk 3. Cleopatra White 4. Corozal 5. Policlínica Family Life Association	1. Hospital San Rafael de Alajuela 2. Hospital Nacional de las Mujeres 3. Hospital México 4. Dr. Max Peralta de Cartago 5. Hospital San Juan de Dios	1. San Juan de Dios Santa Ana 2. Dr. Jorge Mazzini Villacorta Sonsonate 3. Saldaña 4. San Rafael the Libertad 5. Santa Gertrudis San Vicente 6. San Juan de Dios San Miguel 7. La Unión	1. Coatepeque 2. Huehuetenango 3. Quetzaltenango 4. San Benito Petén 5. Amistad Japón 6. Infantil-Elisa Martínez 7. Cobán 8. Antigua Guatemala 9. Cuilapa 10. Escuintla 11. San Vicente 12. Zacapa	1. Metropolitano Dr. Arnulfo Arias Madrid 2. Del Niño 3. Manuel Amador Guerrero 4. Aquilino Tejeira 5. Nicolás A. Solano 6. Santo Tomás 7. José Domingo Obaldía 8. Regional Rafael Hernández
20 new participating facilities in year II (Oct 2010 -Sep 2011)	6. Dangriga 7. Punta Gorda	6. Hospital San Carlos 7. Hospital Nacional de Niños Dr. Carlos Sáenz Herrera 8. Dr. Tony Facio de Limón 9. Hospital Monseñor Sanabria de Puntarenas 10. Hospital Dr. Escalante Pradilla de Pérez Zeledón	8. Ahuachapán 9. Morazán 10. De Niños Benjamín Bloom 11. Rosales 12. Chalatenango	13. Suchitepéquez 14. Retalhuleu	9. Pediátrico del Seguro Social 10. Marvel Iglesias de Aligandi, Guna Yala 11. De los Santos 12. Bocas del Toro 13. Veraguas 14. Herrera
1 additional participating facility year III (Oct 2011 - Sep 2012)				15. Malacatán	
58 Health Facilities Total	**7**	**10**	**12**	**15**	**14**

1. Optimizing Performance and Quality –OPQ– and the Continuum of Care –CoC –

Improve HIV/AIDS provider performance and integrate treatment with community-based support ensuring complementarities and prevention promotion.

During Project Year III (October 2011 to September 2012) the Project provided technical assistance (TA) to the Ministries of Health and Social Security Institutes to empower the central and local levels to implement OPQ to identify and close performance gaps through: targeted trainings; conferences; lectures; and the donation of medical equipment. Follow up visits were conducted quarterly in accompaniment of central level technical staff to monitor implementation of the facilities' gap-closing plans to close the gaps identified in the OQ performance measurements. At the community level, the multi-sector networks received project TA for the implementation of the phases of the Continuum of Care (CoC) for HIV strategy. At this moment all participating CoC networks are in the OPQ application phase. The following tables and graphs show achievements to date with an accompanying discussion of the results.

➢ OPTIMIZING PERFORMANCE FOR QUALITY –OPQ –

During the past quarter, 17 facilities conducted a performance measurement: 213% of the quarterly target. For the past year, 57 facilities conducted a measurement: 106% of the annual target. Of these 57 measurements; 36 (63%) were a third round measurement; 20 (35%) were for the second time; and one was an initial baseline measurement. The only hospital that did not do a measurement was San Juan de Dios of Costa Rica, which requested a postponement until early 2013 due to changes in infrastructure and personnel (Annex 2).

Table 1.1 Optimizing Performance for Quality in Health Services that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to quarterly and annual goals, September 2012

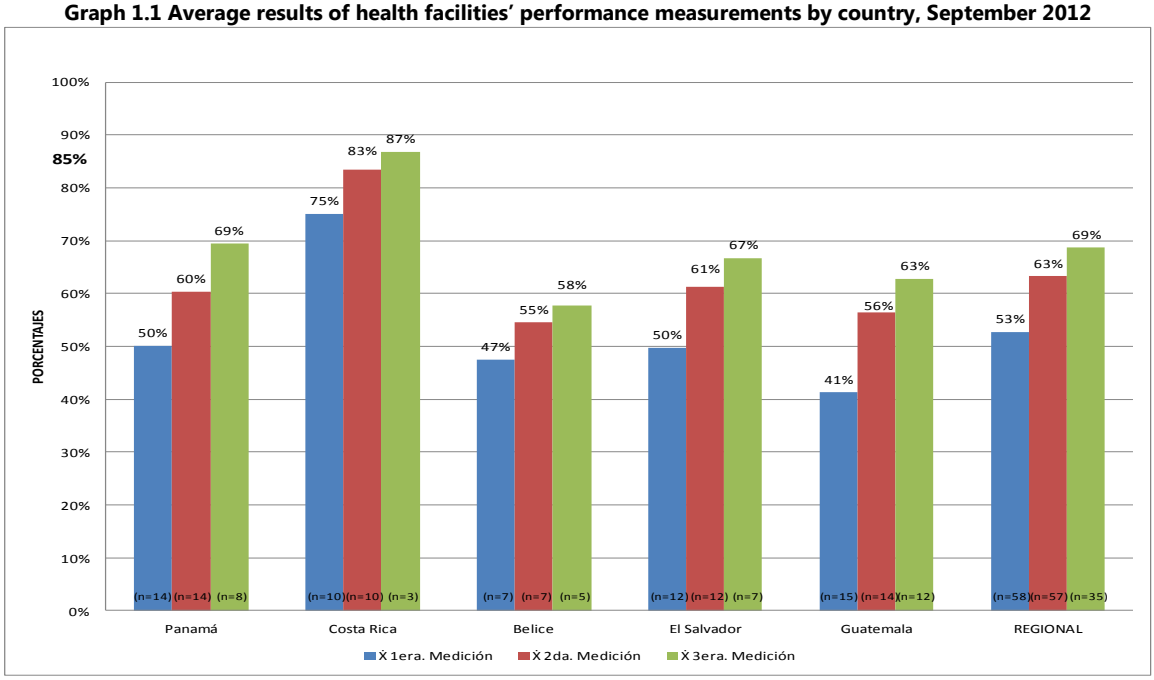
#	INDICATOR	Annual goal	Annual Result	Annual Performance		Quarterly Goal	Quarterly Result
1.1.1.	**% of health services that have completed a performance measurement in the reporting period**	100% (54 of 54)	57	106% (57 of 54)		15% (8 of 54)	213% (17 of 8)
# of health services which have completed a performance measurement in the reporting period		**54**	**57**	**106%**		**8**	**17**
	Belize	5	7	140%		2	1
	Costa Rica	11	9	82%		0	1
	El Salvador	11	12	109%		6	8
	Guatemala	14	15	107%		0	5
	Panama	13	14	108%		0	2

1.1.2.	**% of health services that have an OPQ gap-closing plan in accordance with the last measurement**	100% 54	57	106% (57 of 54)		15% (8 of 54)	213% (17 of 8)
# of health services that have an OPQ gap-closing plan in accordance with the last measurement		**54**	**57**	**106%**		**8**	**17**
	Belize	5	7	140%		2	1
	Costa Rica	11	9	82%		0	1
	El Salvador	11	12	109%		6	8
	Guatemala	14	15	107%		0	5
	Panama	13	14	108%		0	2

Source: M&E Unit, USAID|Central America Capacity Project

Graph 1.1 shows the average result for the 1st, 2nd and 3rd performance measurements. In all of the countries there was an improvement in the average overall result in comparison to the previous measurement. This improvement is due to the commitment and effort of the local multidisciplinary OPQ teams.

Graph 1.1 Average results of health facilities' performance measurements by country, September 2012



Source: M&E Unit, USAID|Central America Capacity Project

All of the 57 hospitals that underwent performance measurements developed a gap-closing intervention plan. In all countries their national authorities, multi-disciplinary teams and local managers are taking steps to appropriate and institutionalize the OPQ methodology. The Ministries of Health of El Salvador, Panama, and Guatemala have requested the expansion of OPQ to other hospitals. In Costa Rica, the CCSS has taken the initial measures to implement OPQ in all

outpatient services. At the local level, the multidisciplinary teams have formed OPQ committees that utilize these instruments as tools for monitoring and supervising the quality of various processes and procedures within their institution.

In-hospital performance gap-closing measures taken include: relocating services; revising and updating various treatment guidelines, protocols and manuals; as well as the development of job aids and information and communication materials. Together with the local community and private sector, they have used the OPQ information to leverage donations supplies and equipment as well as improvements to the facilities' infrastructure. Strategic alliances with groups and projects such as PASMO, PASCA, UNDP, PAHO and the Global Fund have been key to gap-closing including training of the personnel. During the past year the Project donated $150,430 in equipment and supplies to the hospitals in the region to assist them in closing the gaps identified in the performance measurements.

In spite of delays due to: political and administrative changes that affected follow up and necessitated new negotiations and trainings; disease alerts; union strikes; and even an earthquake in Costa Rica, the Project had a satisfactory achievement of its proposed targets.

Belize:

The Belizean regional health authorities and the National AIDS Commission (NAC) led the implementation of the OPQ strategy there. The measurement team consisted of personnel trained in OPQ that performed the measurements in hospitals other than their own. In spite of resource limitations, the multi-disciplinary teams carried out measures to close the performance gaps. This positive change in attitude of the health personnel in regards to improving their service performance supported by targeted trainings made for an improvement in treatment and a more user-friendly service.

During the past year, seven project-supported health facilities performed a performance measurement of which five were third round measurements and two were a second round measurement. Six of the hospitals improved their score with the exception being Corozal Community Hospital, which dropped five points since the previous measurement, largely due to administrative changes (Graph A.1, Country Annex).

Costa Rica:

During the past year the Project provided TA to the Costa Rican Social Security Institute to continue implementing ODC and CoC. The commitment of the central level authorities as well as local personnel facilitated the achievement of a high performance score for most of the hospitals. In order to execute their gap-closing plans, the multi-disciplinary teams secured supplies and job aides and also took a positive attitude towards improving the quality of care. The gaps that persisted largely have to do with the establishments' physical infrastructure.

They carried out nine of the eleven planned measurements during the past year. Calderon Guardia Hospital declined to participate after the first year and San Juan de Dios Hospital requested a postponement of their third round measurement until next year due to changes in the infrastructure and administration. Four of the nine measurements were third round measurements and the other five were second round measurements. Only one of the hospitals with a third measurement improved its score over the previous one. Of the other three hospitals, one maintained its score, and two had decreases since the previous measurement largely due to lack of basic supplies (lack of soap and paper towels in bathrooms).

All of the five hospitals that had a second round measurement improved their overall score as compared to baseline measurement. The hospitals received follow up visits to the measurements that were integrated into their Technical/Administrative Advisory Board meetings.

El Salvador:

Empowerment of the National STI/HIV/AIDS Program (NAP), regional health personnel and hospital teams facilitated implementation during the past year. Regional personnel made visits to hospitals other than their own to perform the performance measurements. Follow up by monthly or bimonthly visits led to a better functional organization and the development and strengthening of: roles, norms, and administrative/technical guidelines to optimize performance. In this manner, all of the hospitals increased their performance.

During the past year they carried out twelve performance measurements in El Salvador: seven of which were third measurements and five corresponded to a second measurement. All of the hospitals increased their performance over the previous measurement (Graph C.1, Country Annex).

El Salvador's success was principally due to maintaining a schedule of periodic meetings to review progress in the hospital gap-closing intervention plan. The principal activity in the plans was developing, revising and updating functional and normative manuals

Guatemala

The Vice Ministry of Hospitals and the NAP program received project support in implementing OPQ. The implementation teams had members from both of those offices and the Project country representative. Hospital teams, as well as the national officials, have been empowered by OPQ. For example, the Escuintla Hospital and the Antigua Hospital achieved important gains through management of internal resources and leveraging external resources to obtain equipment and supplies. The Escuintla Hospital used OPQ findings to secure important contributions from the central level, the municipality and the private sector. The challenge currently facing Guatemalan public hospitals are budget shortages for providing basic supplies and contracting human resources. Constant changes in administration and lack of supplies and equipment resulted in a performance score decrease in some hospitals.

Eight of the twelve third round performance measurements improved their score over the second measurement (Graph D.1, Country annexes). The hospital administration and the OPQ team are committed to implementing the strategy to improve patient services, and through their leadership their hospitals have improved in score. During the past year, there were 15 performance measurements of which: twelve were third round measurements; two second round; and one first round baseline measurement.

Panama

The Directorate General for Health's Office of Facilities and Services for the Population's Health, together with the NAP, led the implementation of the OPQ strategy. These offices together with trained hospital personnel made up the performance verification team. Panama experienced challenges due to: labor strikes; budget limitations; and shortages of basic supplies in the hospitals. This situation affected performance as reflected in the overall measurement scores. During the past year Panama completed fourteen performance measurements: eight of which were third round measurements; and six were second round measurements. Half (4/8) of the hospitals with third round measurements increased their overall performance scores; whereas four of the six second round hospitals improved their score over their previous measurement (Graph E.1, Country Annex). Decreases in performance scores were largely due to lack of basic supplies for infection prevention and inadequate infrastructure, particularly related to availability of sanitary facilities for the clients.

Follow up Visits

During the past year 62% (26/42) of follow up visits between the first and second quarter after the measurement reached a 40% compliance with the activities in the gap-closing plan. Thirty-eight percent (11/29) of the visits between the second and third quarter after the measurement achieved 60% compliance and eight percent (2/26) of visits between the third and fourth quarter after the measurement (and before the subsequent measurement) achieved 80% or more of the activities in the gap-closing plan (Table 1.2).

Table 1.2 Compliance with execution of activities in the gap-closing plan by follow up visit depending upon time lapse since the measurement, September 2012

Country	Time Lapse Between Visits					
	Between first and second quarter after the measurement		Between second and third quarter after the measurement		Between third quarter after the measurement and before the following measurement	
	#	% of compliance with 40% of activities	#	% of compliance with 60% of activities	#	% of compliance with 80% of activities
Belize	5	100% (5 of 5)	2	50% (1 of 2)	5	20% (1 of 5)
Costa Rica	8	63% (5 of 8)	9	33 % (3 of 9)	10	10% (1 of 10)
El Salvador	11	54% (6 of 11)	6	83% (5 of 6)	4	0% (0 of 4)
Guatemala	12	50% (6 of 12)	9	22% (2 of 9)	6	0% (0 of 6)
Panama	6	66% (4 of 6)	3	0% (0 of 3)	1	0% (0 of 1)
Total	42	62% (26 of 42)	29	38% (11 of 29)	26	8% (2 of 26)

Source: M&E Unit, USAID|Central America Capacity Project

The target for the past year was to achieve the third visit in 57 health facilities. However, 46% had a third visit, 51% a second visit and 74% had one or more visits. The annual goal was that 50% (27/54) of the facilities would achieve a "good" compliance (80% of the activities in the plan) in the gap-closing plan) by the third visit. However, only two of the 26 (4%) hospitals with a third visit reached that goal. The primary reason for not achieving this target was budgetary limitations for the hospitals in the region which made for a lack of resources to complete the activities in the gap-closing plan. Rotation of personnel also affected the achievement of this goal (Table 1.3)

Table 1.3 Optimizing Performance for Quality in Health Services that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to quarterly and annual goals, September 2012

#	Indicator	Annual target	Achieved to date		Goal for quarter	Achieved for the quarter
1.1.3	% of health services that achieved good compliance the performance gap-closing plan	50% (at least 27/54 are required to reach 50%)	4% (2 of 57)		54% (7 of 13)	0% (0 of 13)
The achieved is measured by breaking down the Annual target proportionally to the time passed after the measurement.		Of the 54 health services to receive follow up visits, at least 27 must execute 80% of the activities by the third follow up visit to achieve the goal.				
Time passed since the measurement	**Proportional target**					
Less than one quarter	NA	In year III the Project conducted 26 visits within a quarter after the last measurement.				
From 1-2 quarters	The health services must comply with minimum of 40% of OPQ	In year III 42 follow up visits were made to the 57 health services within two quarters after the measurement. 26 of 57 hospitals achieved 40% of the OPQ activities completed by the first.				
From 2 to less than three quarters	The health services must comply with a minimum of 60% of compliance with OPQ	In year III 29 follow up visits were made to the 57 health services between within two quarters after the measurement. 19% (11 of 57) of the hospitals completed 60% of the OPQ activities by their second visit				
From 3 to less than 4 quarters	The health services must comply with a minimum of 80% of OPQ	In year III 26 third follow up visits were made to 57 health services. Two hospitals completed 80% of OPQ activities by the third visit.				

Source: M&E Unit, USAID|Central America Capacity Project

The hospital multidisciplinary teams developed gap-closing plans with feasible activities according to their available resources. The plan is periodically monitored for its compliance. Upon identifying activities that have been completed, the teams analyze other gaps and define new interventions. In this manner, the plan becomes a dynamic tool with the actions of the hospital teams achieving performance improvements as reflected in the increases in the average global performance score for each country (Graph 1.1).

Gaps still pending in the third follow up visits were due to situations such as: multiple changes in political authorities in Guatemala; a dengue alert in El Salvador; medical and union strikes in Panama; and an earthquake in Costa Rica. Compliance with the gap-closing plans was also affected by hospital budgetary limitations in the region and turnover in administrative/ management and operational personnel.

Table 1.4 Optimizing Performance for Quality in Health Services that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to quarterly and annual goals, September 2012

#	Indicator	Annual target	Annual Performance	Target for the quarter	Achieved for the quarter
1.1.4	**% of health services that improved their global rating with regards to their last performance improvement measurement** See Table 1.1 health services with follow up measurements and % of gap-closing activities completed Global Performance Improvement measurement: If the health service achieved between 85-100% in its last measurement, it is categorized as GREEN and it must maintain a rating above 85% in the following measurement If the health service achieved between 60-84% in its last measurement, it is categorized as YELLOW and it must increase its rating by at least 10% in the following measurement or move to the GREEN category If the health service achieved between 0-59% in its last measurement, it is categorized as RED and it must increase its rating by at least 20% in the following measurement or move to the YELLOW category	61% (33 of 54)	41% (23 of 56)	63% (5 of 8)	53% (9 of 17)
		Of the 17 health services that conducted the corresponding measurement during the quarter, 9 met the requirement. Of the 56 health services which conducted the corresponding measurement during Year III, 23 met the requirement.			

Source: M&E Unit, USAID|Central America Capacity Project

Nine out of seventeen health facilities that performed a measurement during the past quarter improved their overall score since the previous measurement, according to the criteria in Table 1.4. During the past year, 41% (23/56) of the facilities improved their overall performance score as compared to the previous measurement according to the criteria in Table 1.4 (See details in the Country Annexes).

Table 1.5 Optimizing Performance for Quality in Health Services that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to quarterly and annual goals, September 2012

#	Indicator	Annual target	Annual Performance	Target for the quarter	Achieved for the quarter
1.1.5	**% of health services with expected improvement** ***See table 1.4 health services with follow-up measurements and % of activities achieved to close gaps*** *Expected Improvement* *# of health services with Expected Improvement:* *-health services obtaining 55% in the second measurement* *-health services obtaining 70% in the third measurement*	61% (At least 33 of 54 to achieve 60%)	54% (30 of 56)	63% (5 of 8)	53% (9 of 17)
		Of the 54 health services that required a follow-up, 20 performed a second measurement and 34 performed a third. The goal for this fourth quarter is for 63% (5 health services of the 8 measured) achieve expected improvement. The measurements performed this quarter are distributed as follows: 4 second measurements and 13 third measurements; 3 of the second measurement and 6 of the third measurement achieved desired performance levels (30 of 56).			

Source: M&E Unit, USAID|Central America Capacity Project

Fifty four percent (30/56) hospitals achieved their desired performance levels (depending upon which round of measurements was carried out): three in Belize; nine in Costa Rica; nine in El Salvador; three in Guatemala (where activities were disrupted due to repeated changes in political authorities); and three in Panama. Hospitals that improved their performance did so through measures taken to secure supplies and equipment, and, in some cases, improvements to infrastructure. Also, personnel were trained in topical areas for the management of HIV including: Introduction to HIV; Patient Care; and Nutrition Therapy (Belize) which strengthened their treatment practices. Trainings were generally done by hospital staff with occasional participation by an invited consultant. A positive change in the attitude of the personnel contributed to teamwork for resolving these performance gaps.

➢ Continuum of Care (CoC)

The implementation of the Continuum of Care for HIV multi-sector network strategy has involved a large effort of negotiation and discussion due to the challenge of coordinating and bringing together different sectors into a shared vision and approach. This process has been complicated by the fact that each participating entity has its own agenda and objectives which often impedes its uninterrupted participation in the network. Nevertheless, the local organizations have displayed an interest in participating in the networks as a comprehensive solution to the HIV problem.

Table 1.6 Progress in implementing the CoC for HIV strategy by country, September 2012

Country	Network Area	FIRST PHASE		SECOND PHASE		THIRD PHASE			
		Presentation Negotiation	Diagnostic	Results	Network Integration	Base-line	Results	Intervention Plan	Follow Up Visit
Belize	Corozal	X	X	X	X	X	X	X	X
Costa Rica	Desamparados	X	X	X	X	X	X	X	X
El Salvador	La Unión	X	X	X	X	X	X	X	X
Guatemala	Escuintla	X	X	X	X	X	X	X	X
Panama	Colón	X	X	X	X	X	X	X	X

The networks in Corozal in Belize, Desamparados in Costa Rica, La Unión in El Salvador, CODESIDA in Guatemala and Colón in Panama are implementing the CoC strategy. The five networks have already completed the negotiation, diagnostic, formation, baseline performance measurement, and development of the gap-closing plan phases, achieving 100% of the target by June 2012 (Table 1.7).

Table 1.7 Optimizing Performance for Quality in Networks that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to quarterly and annual goals, September 2012

#	INDICATOR	Annual Target	Achieved to date	Annual Performance		Goal for quarter	Achieved for the quarter
1.2.1	# of networks formed to implement CoC strategy	5	5	100%		2	NA
1.2.2.	# of formed networks that have been supported in the implementation of the CoC strategy	5	5	100%		2	NA

Source: M&E Unit, USAID|Central America Capacity Project

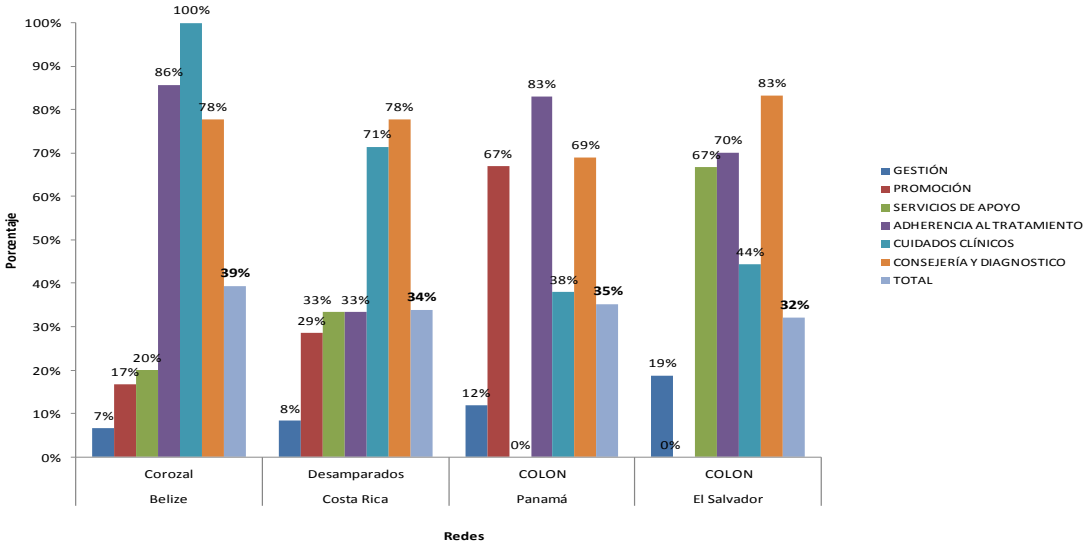
During the past year the five networks conducted their baseline performance measurement. CODESIDA in Guatemala conducted its initial measurement in August of 2011, and its second measurement was due in August 2012. However, the network requested a postponement until the first quarter of the coming project year due to conflicts with planned training activities and the national CoC forum during the past quarter (Table 1.8).

Table 1.8 Optimizing Performance for Quality in Networks that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to quarterly and annual goals, September 2012

#	Indicator		Annual Target	Annual Performance		Goal for quarter	Achieved for the quarter
1.2.3	# of networks that have completed performance measurements within the reporting period		5	4		0	NA
	Country	**Network**					
	Belize	Corozal	1	1		1	0
	Costa Rica	Desamparados	1	1		0	NA
	El Salvador	La Unión	1	1		0	NA
	Guatemala	CODESIDA	1	0		1	0
	Panama	Colón	1	1		0	NA

Source: M&E Unit, USAID|Central America Capacity Project

Graph 1.2 Results from first measurements of the multisectoral networks that were done in Y3 By measurement area and country



Source: M&E Unit, USAID|Central America Capacity Project

The overall baseline network performance scores ranged from 32% to 39% (average of 35%). Counseling, diagnosis, and adherence were the components with the highest performance scores, due to the strengthening of treatment of PLH in the HIV clinics. The areas presenting the greatest challenges are: management; promotion; and support services. These data complement the information obtained in the initial situational analyses which reflects the lack of GOs and NGOs

offering these services. Improving management will require a standardization of procedures and work instruments of the network member organizations. The referrals/counter referrals system also requires strengthening.

Each network developed a performance gap-closing plan identifying priority gaps for optimizing the respective networks performance for quality (Table 1.9).

Table 1.9 Optimizing Performance for Quality in Networks that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to quarterly and annual goals, September 2012

#	Indicator		Annual target	Annual Performance		Goal for quarter	Achieved for the quarter
1.2.4	# of networks that have an Intervention Plan for performance improvement according to results from the last measurement		5	4		2	1 of 2 (50%)
			Of the 5 networks, 4 now have an Implementation Plan for gap-reduction in CoC.				
	Country	**Network**					
	Belize	Corozal	1	1		1	NA
	Costa Rica	Desamparados	1	1		0	NA
	El Salvador	La Unión	1	1		0	1 of 1 (100%)
	Guatemala	CODESIDA	1	0		1	0 of 1 (0%)
	Panama	Colón	1	1		0	NA

Source: M&E Unit, USAID|Central America Capacity Project

In Belize the CoC for HIV strategy has been formally adopted by the NAC and is being implemented nationally. The Costa Rica/Desamparados network has focused on closing gaps by developing standardized information, education and communication materials across the network members. The El Salvador/La Union network, consisting of over 20 GOs/NGOs with private sector participation, presented its achievements in the national CoC forum. The Guatemala/CODESIDA-Escuintla network was an active participant in the national forum there, reiterating their commitment and inviting other organizations to join. The Panama/Colon network of approximately 20 organizations has monthly meetings to work on closing the performance gaps beginning with the standardization and training of network members in HIV and the application of OPQ.

The Project has supported the celebration of World AIDS Day in all five countries as well as other activities requested by the ministries of health related to improving quality and elaboration of the annual operational plan.

The network members have received capacity strengthening through workshops on: formation of the networks; assertive communication; and working as a team and conflict resolution. The next steps will be to continue with the gap-closing focusing on: reducing stigma and discrimination and facilitating adherence to treatment through concrete steps to develop the system of referrals/counter-referrals in each network.

LEARNING FOR PERFORMANCE (LFP) STRATEGY

The Project applies the LFP methodology to in- and pre-service training activities. LFP is a systematic process of instructional design directed to persons and teams involved in strengthening the training components of performance improvement programs for health personnel. In the first phase the Project transferred the methodology to: teachers; trainers; curricula designers; researchers; supervisors and managers involved in training.

Health workers are the most valuable resources of the health system, for which reason the Project supports the development of a competent training team to update the health workers' knowledge and skills to perform quality service and respond to constantly changing needs and conditions. LFP covers certification of trainers for in-service, pre-service training and to those who support training including: health providers; multi-sector network participants; training institution personnel; and pre-service students.

2. IN-SERVICE TRAINING

Provide in-service training and updates to HIV/AIDS care providers from the public, private, and NGO sectors. For example: diploma and other short courses on specific themes related to comprehensive care and treatment of HIV/AIDSA. Support the updating, development and reproduction of materials and/or scholarships for participation in courses at private institutions. At a minimum, topics to be covered include: ART; HIV-TB co-infection; bio-safety; performance improvement; and stigma and discrimination.

In-service trainings are focused on closing gaps in knowledge; skills; and/or attitudes in specific thematic areas identified by the performance measurements of the health facilities. Trainings are designed not only to improve knowledge, but also to focus on the application of the acquired knowledge as a learned skill. Table 2.1 presents achievements during the past quarter and project year.

Regionally, the Project trained 84 trainers in Learning for Performance (LFP), 108% of the annual target. Belize, Costa Rica and El Salvador exceeded their annual targets, while Panama was at 81% of the target. Guatemala only trained 11 health providers, 37% of the target, due to constant changes in the health authorities and hospital personnel which impeded the programming and execution of project activities.

Table 2.1 In-service trainings implemented
Achievements regarding to quarterly and Y3 annual goals, September 2012 Regional

#	INDICATOR	Annual target	Achieved annual	Annual Performance		Goal for quarter	Achieved for the quarter
2.1.1	# health service providers trained as trainers in Learning for Performance	78	84	108%		0	11
	Belize	6	19	317%		0	NA
	Costa Rica	12	22	183%		0	NA
	El Salvador	14	19	136%		0	NA
	Guatemala	30	11	37%		0	11
	Panama	16	13	81%		0	NA
2.1.2	# health service providers who successfully completed the training program. Topics include OPQ and themes in HIV including, gender, stigma and discrimination	1655	1991	120%		570	1193
	Male	811	536	66%		281	293
	Female	844	1455	172%		289	900
	Doctors	35	286	817%		15	149
	Male	15	147	980%		6	69
	Female	20	139	695%		9	80
	Nurses	893	710	80%		305	414
	Male	437	80	18%		150	51
	Female	456	630	138%		155	363
	Other Personnel	727	994	137%		253	630
	Male	356	310	87%		126	173
	Female	371	685	185%		127	457
2.1.3	% of trainees who achieved the minimum required competencies	70%	96% (1991 of 2063)	96% (1991 of 2063)		70%	97% (1202 of 1228)

Source: M&E Unit, USAID|Central America Capacity Project

During the fourth quarter the Project reached 209% of its target (1193/570) of health providers receiving competency-based training, due to the completion of pending trainings from the third quarter in addition to the scheduled trainings for this past quarter. The Project achieved 120% (1991/1665) of the annual target for the number of health service providers who successfully completed the training program. Targets by sub-group were surpassed for doctors in all countries (286/35). Belize was the only country that exceeded the target for nurses. In terms of other health personnel (administrative, kitchen, laundry, janitorial, etc.) all of the countries except for Belize achieved their targets (See Table 2.2).

In accordance with the Project's application of LFP, only persons with a minimum of 16 hours in-course, and who also achieve a minimum of 80% on the post-test are certified as trained. In addition, the Project verifies that the trainees have acquired a minimum score of 80% on the desired performance skills.

The Project standard is that 70% of in-service personnel who enter into a training program meet the requirements. During the fourth quarter, 97% (1202/1228) of the participants that entered training achieved this criterium. The annual achievement for last year was 96% (1991/2063).

Table 2.2 Personnel trained in competencies disaggregated by country, profession and gender (LFP Methodology) October 2011 to September 2012

Metas FYIII Programadas					Medicos								Enfermeras								Otros								Total			
Pais	Medicos	Enfermeras	Otros	Total	Total Femenino	Femenino (N)	Femenino %	Meta Masculino	Masculino (N)	Masculino %	Total Medicos	Alcanzado	Total Femenino	Femenino (N)	Femenino %	Meta Masculino	Masculino (N)	Masculino %	Enfermeras Total	Alcanzado	Total Femenino	Femenino (N)	Femenino %	Meta Masculino	Masculino (N)	Masculino %	Total Otros	Alcanzado	Femenino	Masculino	Gran Total	Alcanzado %
Belize	3	54	55	112	2	8	400%	1	8	800%	16	**533.33%**	28	59	211%	26	0	0%	59	**109.26%**	28	26	93%	27	12	44%	38	69.09%	94	19	113	**100.89%**
Costa Rica	7	162	132	301	4	24	600%	3	25	833%	49	**700.00%**	83	88	106%	79	20	25%	108	**66.67%**	67	160	239%	65	86	132%	246	186.36%	272	131	403	**133.89%**
El Salvador	7	161	132	300	4	23	575%	3	45	1500%	68	**971.43%**	82	137	167%	79	7	9%	144	**89.44%**	67	117	175%	65	73	112%	190	143.94%	277	125	402	**134.00%**
Guatemala	9	284	223	516	5	39	780%	4	32	800%	71	**788.89%**	145	196	135%	139	37	27%	233	**82.04%**	114	236	207%	109	68	62%	304	136.32%	471	137	608	**117.83%**
Panamá	9	232	185	426	5	45	900%	4	37	925%	82	**911.11%**	118	150	127%	114	16	14%	166	**71.55%**	94	146	155%	91	71	78%	217	117.30%	341	124	465	**109.15%**
Total	35	893	727	1655	20	139	695%	15	147	980%	286	**817.14%**	456	630	138%	437	80	18%	710	**79.51%**	370	685	185%	357	310	87%	995	136.86%	1455	536	1991	**120.30%**

Source: M&E Unit, USAID|Central America Capacity Project

The discrepancies between the target numbers and the number reached, by job category is that the Hospital Directors designate the training participants, and in spite of the fact that the themes and target groups were discussed previously, some categories such as doctors trained were over the target whereas the number of nurses trained did not meet the target (Table 2.2).

The training topics were divided by specific themes and methodologies (e.g. OPQ, LFP and CoC). Training contents, decided according to gaps identified in the performance measurements, were: stigma and discrimination; bio-safety; and voluntary counseling and testing. Additionally, strengthening of the health teams was added, which seeks to develop OPQ team-working skills through assertive communication and conflict management. This intervention consisted of five performance factors (clear definition of job expectations; clear and immediate feedback; adequate physical work environment; motivation and incentives; and skills and knowledge) focused on gaps in personal motivation and incentives and achieved that the health teams linked motivational factors with hospital performance, oriented towards closing performance gaps and meeting standards. Training in strengthening the health teams empowers them to convert their ideas into innovations feasible for application in their daily routine.

Of the 96 trainings by theme and country, Belize developed five in: stigma and discrimination; LFP; OPQ nutrition; and for the Corozal network, health team strengthening. Although Costa Rica got off to a slow start due to planning problems and the need to get formal approval from the Center for Development of Strategic Information in Health of the CCSS (CENDEISS), the country team made an extraordinary effort during the last quarter to reach the annual goals for OPQ, LFP and the topics of OPQ, stigma and discrimination, VCT, bio-safety, and health teams strengthening. The Desamparados CoC network also trained its members in VCT.

El Salvador set its annual targets based on the first three quarters taking into account that emergencies (and therefore, delays) due to dengue and other natural disasters often happen during the final quarter of the Project year. They trained 402 health providers in LFP, bio-safety, VCT and Stigma and discrimination (Table 2.2).

Guatemala was affected during practically the whole project year by constant changes in the MOH due to the change in government. LFP training was suspended various times, complicating the formation of hospital training teams. In some cases, previously trained staff no longer worked in the hospitals. It was not until the fourth quarter that they were able to certify 11 health workers, 37% of the annual goal. Staff of the Central Level Training Department also received training in LFP to familiarize them with the Project methodology for curricula development and competency-based training. The Project hired a consultant to finish the VCT training through a total of 18 workshops. In parallel, another consultant conducted six hospital trainings in strengthening health teams and two gap-closing trainings were conducted in the San Vicente Hospital closing the year with 27 gap-closing workshops.

Panama completed 25 workshops in LFP, OPQ, bio-safety, stigma and discrimination, and strengthening health teams with the support of a local consultant.

In spite of closing with a 120% achievement of the target, there were numerous challenges during the past project year for training health providers. Besides the interruptions to programming due to elections in Guatemala, El Salvador and Belize, it is important to note that the region is vulnerable to disease outbreaks such as dengue, respiratory infections and diarrheal diseases as well as to natural disasters including hurricanes, floods, landslides and earthquakes.

One important challenge is maintaining the gap-closing training programming and participants' attendance from referring institutions from different sectors. Together with the previously mentioned conditions additional limitations include the difficulty in training personnel outside of the hospital, despite the fact that much of these institutions lack adequate training facilities. Additionally, health personnel find it difficult to participate in a second round of training, in which case agreements have been made with some hospitals with adequate facilities to do the second round after an interval of 1-2 weeks within the hospital, if feasible.

Achievements during the past year include the development of competencies and capacities, both technically and in terms of improving the institutional culture (labor relations, conflict resolution). In-service training has led to improved hospital functioning which in turn should lead to an improved quality of patient services. Among the next steps for the coming project year are the development of separate curricula in nutrition and anti-retroviral treatment through the application of LFP (Belize has already begun training service providers in nutrition and HIV). These curricula will be evaluated and adapted to each country.

3. PRE-SERVICE TRAINING

Strengthen pre-service training of care providers with updated HIV/AIDS content and increase access to early diagnosis with a VCT strategy. The Project will support updating and incorporating appropriate modules and materials related to comprehensive HIV/AIDS care into the training programs of the medical and other health/social service providers. Topics to be covered at a minimum include: antiretroviral therapy, TB-HIV co-infection, bio-safety, performance improvement, and stigma and discrimination.

During the past year the Project continued strengthening updated training programs in HIV for higher learning institutions. These activities focused on:

- Training university faculty in LFP
- Updating HIV curricula
- Training of teachers and students in VCT, including testing for HIV
- Technical and financial support for the National HIV testing day in universities in coordination with the MOH

➢ UPDATING CURRICULA IN INSTITUTIONS OF HIGHER LEARNING

During the second year the Project presented proposals for updating the HIV curricula in five higher learning institutions, one in each country: Belize University (Schools of Nursing, Social Work, Medical Laboratory and Pharmacy); Costa Rica University (School of Nursing); Matías Delgado Medical School in El Salvador; the Nursing School of Guatemala; and Panama University Nursing School.

Activities during the past year to implement the proposed HIV curricula include: 1) Reaching a consensus on and finalizing the curricula with each institution of higher learning; 2) Training faculty in implementing the proposed curricula; 3) Incorporating modifications indicated by the universities into their study program; 4) final editing and incorporation of graphics and printing of documents; and 5) implementation of the curricula as part of their study program.

In each country there were specific challenges and responses from the faculty and educational authorities.

Belize is the only country incorporating the HIV curricula in Schools of Nursing, Social Work, Medical Laboratory and Pharmacy. The course "Education for Health: HIV and other STIs" began in January and ended in May. This three credit course was a requirement in the Schools of Nursing, Allied Health, and Social Work.

Next Steps: Beginning in January the course also will be offered to all students as an optional course in the University due to joint efforts of the University and the NAC. Students have adopted the methodology and transmitted knowledge throughout the whole University via demonstrations and posters.

Costa Rica made considerable progress during the past few months. The faculty received training in the methodology and HIV-related contents; and together with the University authorities are including the relevant modifications to have it included as a course offering in 2013.

Nest Steps: The curriculum will be presented to the new Nursing College Board with support of the Chief of the MOH Strategic Planning Unit and Evaluation of Activities for implementation of the HIV curricula in the 8 nursing schools in the country.

El Salvador made the modifications requested by the Matías Delgado University and will be going to print. Since July the contents have been taught in the 2nd to 7th year of medical studies and also in the postgraduate school.

Next Steps: The MOH has received positive comments on the HIV curricular strengthening developed for and with Matías Delgado University and local expects to establish a working group with representation of all of the health training schools to apply LFP to the proposed HIV curriculum to harmonize and strengthen the HIV training across all of the health careers.

Guatemala concluded with the training of all faculty from the National Nursing School. The curriculum are being edited with graphics in preparation for final printing.

Next Steps: The Rafael Landívar Medical School displayed a strong interest in including the HIV curriculum in its study plan based on experience with the VCT workshops. Coordination is on-going with the MOH Sub-Directorate for Training, which is in process of revising and updating the curriculum in the five nursing schools and the private and public sector nurse auxiliary training schools, with the idea of having a standardized HIV curriculum.

Panama University held three validation workshops with faculty and students to review the educational materials to be included in the "Adult Health II" course in the fourth semester of the Sciences in Nursing professional degree program.

Nest Steps: Continue coordination with the Academic Vice Rector and President of the Panama University Technical Coordinating Committee to refine the details of implementing the curriculum in other health-related professional training schools. In parallel, the implementation of the curriculum in the Panama Campus was incorporated into the Regional University Center of Azuero of Panama University.

The curricula of the Matías Delgado University in El Salvador and the Guatemalan Nursing School are in their final editing and duplication phases, to be used during the coming year. Meanwhile, the universities of Belize, Costa Rica and Panama will undertake final editing during the coming quarter (October-December 2012 - Table 3.1).

Table 3.1 Updating curriculum in selected institutions of higher learning, Achievements regarding to Y3 quarterly and annual goals, September 2012

#	INDICATOR	Annual target	Achieved annual	Annual Performance		Goal for quarter	Achieved for the quarter
3.1.1	# of technical proposals for curriculum update to include themes related HIV	5	5	100%		5	0
3.1.2	# university teachers who successfully completed the training program in LFP	30	40	133%		0	NA
3.1.3	# of higher education institutions that implemented the updated curriculum with themes in HIV for their teaching program.	5	5*	100%		5	0

Source: M&E Unit, USAID|Central America Capacity Project
*Data pending confirmation

➢ PRE-SERVICE TRAINING PROGRAM IN VCT

From July through September the Project provided fourteen trainings for university faculty and students in: Costa Rica (6); Guatemala (4); Panama (3); and El Salvador (1). These trained faculty and student peers were part of support teams for the Voluntary HIV Testing Days in their respective universities. This VCT activity is always conducted in coordination with the MOH NAP in each country.

During the final quarter the Project reached 89% (285/320) of the pre-service training in VCT target; 8 faculty members and 277 students. In relation to the annual regional target, the Project reached 107% (781/731) successfully completing the VCT training curriculum, 105% for faculty (96/91) and 107% for students (685/640).

Table 3.2 Pre-service training implemented. Achievements regarding to Y3 quarterly and annual goals, September 2012

#	INDICATOR	Annual target	Achieved annual	Annual Performance		Goal for quarter	Achieved for the quarter
3.2.1	# of pre-service students that successfully completed the VCT training program	731	781	107%		320	285
	# of university teachers trained as trainers of VCT	91	96	105%		0	8
	Male	48	17	35%		0	2
	Female	43	79	184%		0	6
	# of student (pairs) trained in VCT	640	685	107%		320	277
	Male	314	143	46%		156	55
	Female	326	542	166%		164	222

Source: M&E Unit, USAID|Central America Capacity Project

Performance in Panama was lower both for faculty (67%) and students (88%) due to numerous University closings because of strikes and other causes (Table 3.3)

Table 3.3 Overview of pre-service training disaggregated by country, profession and sex (LFP Methodology) October 2011 – September 2012

Metas FYIII				Catedraticos								Estudiantes								Total			
Pais	Catedraticos	Estudiantes	Total	Meta Femenino	Femenino (N)	Femenino %	Meta Masculino	Masculino (N)	Masculino %	Total Catedraticos	Alcanzado	Meta Femenino	Femenino (N)	Femenino %	Meta Masculino	Masculino (N)	Masculino %	Total Estudiantes	Alcanzado	Femenino	Masculino	Gran Total	Alcanzado %
Belize	7	40	47	3	3	100%	4	4	100%	7	100.00%	20	27	135%	20	12	60%	39	97.50%	30	16	46	**97.87%**
Costa Rica	21	150	171	10	16	160%	11	4	36%	20	95.24%	76	134	176%	74	36	49%	170	113.33%	150	40	190	**111.11%**
El Salvador	21	150	171	10	27	270%	11	3	27%	30	142.86%	76	171	225%	74	37	50%	208	138.67%	198	40	238	**139.18%**
Guatemala	21	150	171	10	22	220%	11	3	27%	25	119.05%	76	88	116%	74	48	65%	136	90.67%	110	51	161	**94.15%**
Panamá	21	150	171	10	11	110%	11	3	27%	14	66.67%	76	122	161%	74	10	14%	132	88.00%	133	13	146	**85.38%**
Total	91	640	731	43	79	184%	48	17	35%	96	105.49%	324	542	167%	316	143	45%	685	107.03%	621	160	781	**106.84%**

Source: M&E Unit, USAID|Central America Capacity Project

➢ HIV TESTING DAY

The university testing days were conducted in coordination with the MOH/NAP and the university authorities. The objective was to improve access to the test with pre and post-test counseling as well as to give the VCT trainees practical experience in applying what they learned.

The Project reached 77% (10/13) of the annual goal of number of participating universities: having testing days in: Belize – one; Costa Rica – two; El Salvador – four; Guatemala – one; and two in Panama (Table 3.4). Countries marked with an asterisk are those that conducted the activity, but are still lacking formal documentation of the event by the university. This is due to the test results still being evaluated with the MOH not having released the data (Table 3.4).

Table 3.4. National Testing Day,
Achievements regarding to Y3 quarterly and annual goals, September 2012

#	INDICATOR	Annual target	Achieved annual	Annual Performance		Goal for quarter	Achieved for the quarter
3.3.1	# of universities that provide VCT, with pre and post-test counseling according to national and international standards	13	10*	77%*		0	7*
	Belize	1	1	100%		0	NA
	Costa Rica	3	2*	66%*		0	NA
	El Salvador	3	4*	133%		0	4*
	Guatemala	3	1	33%		0	1
	Panama	3	2*	66%*		0	2*
3.3.2	# of persons who received VCT, with pre and post-test counseling according to national and international standards	1300	2162*	166%		0	1918*
	Belize	200	228	114%		0	NA
	Costa Rica	300	16	5%		0	NA
	El Salvador	300	1036*	345%		0	1036*
	Guatemala	300	437	146%		0	437
	Panama	300	445*	148%		0	445*

Source: M&E Unit, USAID|Central America Capacity Project
*Data pending confirmation from MOH

The Project exceeded the annual target for number of tests with counseling with 166%, in spite of the fact that Costa Rica only achieved 5% (16/300) of its target due to lack of budget for the test reagents.

Table 3.5 Results for HIV testing performed in higher-learning institutions.
October 2011 to September 2012, by country

Country	Number HIV tests performed	Number of positive results	Number of negative results	Number of indeterminate results	HIV prevalence
Belize	228	0	228	0	0%
Costa Rica	16*	0	16	0	0%
El Salvador	1036	12	1024	0	1.2%
Guatemala	437	1	436	0	0.2%
Panama	445*	1	444	0	0.2%
Total	**2162**	**14**	**2149**	**0**	**0.6%**

Fuente: M&E USAID|Proyecto Capacity Centroamérica
* Data pending confirmation from MOH

The test results outside of El Salvador (1.2%) were less than or equal to 0.2% (Table 3.5). The results for El Salvador (1.58% in males and 0.85% in females) are a bit worrisome and merit further investigation.

Next Steps: Due to the relatively low seroprevalence in this population for the past three years, compared to that of the populations at higher risk (MSM, Sex Workers and some ethnic populations) that are fueling the concentrated epidemic in Central America, the Project will concentrate efforts on expanding the number of universities applying the HIV curriculum.

4. INFORMATION TECHNOLOGY

Development/use of information technology for distance training, care and treatment conferences, information dissemination, and a training information system.

➢ MOBILE TELEPHONE TECHNOLOGY

The Project began introducing learning re-enforcement through mobile telephone technology (mLearning) during the second year with personnel participating in the HIV diploma course. During the third year a new mLearning strategy was implemented for pre-service university students taking the VCT course. The Project did a feasibility test of sending the messages through the Central American cellular telephone companies via the Front Line SMS, 1.7.0-Beta- 17 software. The program sends scheduled follow up messages to participants and can register responses to questions. Through a pilot test it was found that the technology functioned in Guatemala, El Salvador and Panama.

The Project invited VCT students in Guatemala and El Salvador to voluntarily participate in the mLearning knowledge re-enforcement trial; 49 Guatemalan students and 66 from El Salvador volunteered to participate. The Guatemalans were randomly assigned to three groups: the first group of 16 received 10 messages related to the training material and had the opportunity to respond to multiple-choice questions and received immediate feedback if their response was correct, and, if not, were immediately informed of the correct answer. The second groups of 16 received the same 10 messages, but was not provided with questions. The third group, serving as a control, received 10 messages not related to the course material. All three groups will receive a follow up post-test (in addition to the one they received at the end of the course) to determine if the mLearning supported retention of the course information

Students in El Salvador were randomly assigned to two groups of 33: one group receiving the 10 messages related to the course contents; and the other group (the control) receiving the 10 unrelated messages. Both groups will receive the post-test to determine if there was any mLearning effect on retention.

The sending of messages began in September and only three messages have been sent to each group so far. The follow up post-test will take place next quarter.

Table 4.1 Implementation of mLearning strategy that is integrated and used in the training and knowledge reinforcement of HIV topics. Achievements regarding to Y3 quarterly and annual goals, September 2012

#	INDICATOR	Annual target	Achieved annual	Annual Performance		Goal for quarter	Achieved for the quarter
4.1.1.	% of people who participated in m-learning strategy as part of HIV training and knowledge reinforcement program	50%	0%	0%		NA	0%
4.1.1.1.	% of people registered in the m-learning program that confirmed having received messages	75%	0%	0%		NA	0%
4.1.2.	% of health care providers registered in the m-learning strategy who maintained a minimum score at the end of the intervention **	65%	0%	0%		NA	0%

Source: M&E Unit, USAID|Central America Capacity Project

** Minimum desired knowledge: "it is defined as Post-test m-learning great or equal than Post-test in training R2 or R3 (Diploma) in selected topics". To obtain a post Test grade, the Post test values were used in each learning modules. The average of these values was compared to the value from the final exam.

➢ HUMAN RESOURCE INFORMATION SYSTEM (HRIS)

The Project is supporting the ministries of health and in particular the NAPs in managing and follow up of trained human resources with the goal of systematizing and updating the human resources training databases in Costa Rica, El Salvador, Guatemala and Panama. PAHO has already established a regional network to strengthen the human resources for health (HRH) situation in the region. The Project has established a strategic alliance with PAHO in this effort through the presentation of the iHRIS software platform, developed by IntraHealth, via a Webinar session with the members of the regional network. This presentation was effective in stimulating interest in its implementation in project countries. Following is progress by country:

Costa Rica: CENDEISS has an HRIS that meets their needs. However, CENDEISS detected some problems, e.g. duplication of information that impedes their ability to produce accurate reports and use the data for decision making and HRH planning. They have requested the development of a tool that would purge the system of duplicate records. From June to August the Project held a number of virtual meetings with them to determine the parameters for a data cleaning module and they are now reviewing a letter of commitment from the Project to complete the task.

El Salvador: In May the Project signed a MOU with the Directorate of Human Resources to construct the HRIS module using the iHRIS software platform in coordination with the technical support from PAHO. iHRIS contains the following sub-systems:

- iHRIS Manage: Performs human resources management (HRM) functions including a training module.
- iHRIS Qualify: A training and licensure tracking database.
- iHRIS Plan: A tool for monitoring health workforce needs.
- iHRIS Retain: A tool for costing health workforce retention interventions.

Under the MOU, the Project hired an IT consultant in charge of making the necessary modifications and adaptations to iHRIS according to the specifications of the needs of the MOH with technical support from the IntraHealth headquarters in Chapel Hill, NC.
The MOH formed a multidisciplinary counterpart team of the Directorates of Human Resources (DHRH), and Information Technology and Communications (DTIC) which together decided to implement iHRIS in the MOH. This team, together with project personnel, analyzed the requirements for implementing iHRIS in the MOH network server and defined the structure, fields and functions to be incorporated into the system.

During the fourth quarter the Project headquarters and regional office experts and conducted an iHRIS implementation workshop in San Salvador. The result was the formation of a team of DTIC developers to install iHRIS on the MOH network servers and to make the adaptations and modifications specified by the DHRH to modify the iHRIS database according to their needs (Table 4.2).

The training focused on transferring the capacity to the national team to make the needed modifications to the system. Topics included: customizing the system for the MOH; changes in the data model; changes in and creation of formats and reports; data migration to/from other databases; and management of iHRIS and the I2CE framework. They also implemented a "bazaar" version control system to systematize changes made by the developers and have created a Latin-American-Caribbean regional development team https://launchpad.net/~ihris-lac.

Also present at the workshop was a technical team from the Guatemala MOH to share experiences and lessons learned from El Salvador to facilitate iHRIS implementation in Guatemala.

Guatemala: A Guatemalan team composed of advisors to the Vice Minister of Administration and the MOH Health Information system (SIGSA) participated as observers in the San Salvador iHRIS workshop. They reported back that there were many similarities between the two systems and that it would be feasible to implement iHRIS in Guatemala. The Vice Minister for Administration approved the plan to install and implement iHRIS in the MOH.

Panama: The Project presented iHRIS to the NAP and Directorate of Health Services in Panama who stated that the MOH did not have an HRIS. The next step will be to make an official presentation, in accompaniment with PAHO, for their consideration to the DHRH, the Information Directorate and other departments

Table 4.2 Establishing information systems for in-service training for MOHs and/or Social Security Institutes, Achievements regarding to Y3 quarterly and annual goals, September 2012

#	INDICATOR	Annual target	Achieved annual	Annual Performance		Goal for quarter	Achieved for the quarter
4.2.1	# of information systems for trained HR that are developed or contexualized	2	0	0%		0	0
4.2.2.	# of information systems for trained HR that are in use	3	0	0%		0	0
4.2.3.	#countries with at least two central level personnel using the info System for training HR	3	2	67%		0	2

Source: M&E Unit, USAID|Central America Capacity Project

5. SYSTEMATIZATION AND INSTITUTIONALIZATION

During the past year the Project has made notable progress in the institutionalization of the OPQ methodology currently being implemented in 58 hospitals. Guatemala, Panama, El Salvador and Costa Rica consolidated the appropriation stage in which the central, regional and local levels took a leadership role demonstrating initiative and empowerment.

OPQ implementation has had a high degree of participation by multidisciplinary actors from hospital management and the technical and operational personnel. Most hospitals have a quality committee that monitors, supervises and follows up on the gap-closing plans. Every country now has a trained multidisciplinary OPQ team at the central level of the MOH that guides implementation through the hospital quality committees.

In Guatemala and Panama the central level NAP and Directorates of Health Services (and Vice Ministry of Hospitals in Guatemala) have led the OPQ process. Both countries have an institutionalization plan within the MOH quality improvement framework.

In Guatemala the hospitals themselves planned their measurements during the coming quarter, demonstrating the capacity of the committees and reducing the need for project TA. The MOH formally requested the expansion of OPQ to fifteen more hospitals in order to have national coverage of the methodology.

In Panama the Regional Directors are actively seeking the expansion of OPQ to the primary care level with the methodology well-positioned in the MOH. The principal counterpart will be the Directorate for Health, which has delegated the Chief of Population Services as the implementing agency in fourteen hospitals: nine of the MOH; three of the SSI; and two that are combined MOH/SSI services.

The MOH decentralized the delegation of the coordination in Belize to the regional managers. Institutionalization negotiations with the MOH require a significant effort due to the complexity of its structure and changes in the authorities following the national elections. OPQ is well positioned and implemented in four of the five health areas in Belize. The NAP has approved the methodology, but has not played an active role in implementation. There is coordination at the central level with the Accreditation Unit that uses the OPQ instrument to monitor the hospital laboratories. Moreover, the Planning Unit expects OPQ to become part of the health worker job descriptions. The Director of Health Services has not participated yet; however, the NAC has supported the strategy. NGOs and civil society organizations that participate in CoC know the methodology and are strategic allies in seeking institutionalization. PAHO and UNDP are also strategic allies.

The Costa Rican Social Security institute formed a Quality Committee with a Model for Guaranteeing Quality that has adopted OPQ as the implementation methodology. The Medical Administration, which is a higher-level authority, approved the expansion of the model to the outpatient clinics and support services at the primary and secondary level. They will implement a pilot in one region this coming year expecting to get full national coverage of OPQ within two years. The principal counterparts are the Directorates of Service Development and Networks. The measurement instruments will be validated prior to initiating the pilot.

In El Salvador the MOH created the National Quality Committee, including OPQ in its strategic and operational plans. Each hospital has its own Quality Committee with OPQ currently being implemented in 12 hospitals with the MOH hoping to extend coverage to all 30 national hospitals.

OPQ Champions Workshop

Guatemala and El Salvador each carried out a "Champions" workshop to share experiences and lessons learned by the multidisciplinary teams in implementing OPQ and achieving its institutionalization. Participants included three representatives from each hospital and the central level. During the workshop OPQ was updated with a focus on the identification, analysis and approach to the five factors that influence performance bringing further clarity to the prioritization activities and implementation of the gap-closing plans. The presentation of successful experiences will be systematized and incorporated into the OPQ manual along with an institutionalization plan.

In El Salvador they ended the workshop concluding that OPQ made for improvements in internal processes. This improvement takes place when all of the parts of a work area know what they must do to reach a more optimal use of resources and time. This internal organizational improvement achieves a more fluid communication in accordance with established responsibilities and objectives, in turn making for more motivated personnel and effective teamwork contributing to a collective improvement in the hospital.

The participants committed to sharing experiences with hospitals not yet implementing OPQ to spread the awareness of the results and benefits recognizing that OPQ provides an opportunity to analyze, simplify, improve, and document productive procedures that directly affect the quality of hospital services. This awareness should generate a framework to promote and establish institutionalization.

The Vice Minister of Hospitals inaugurated the workshop in Guatemala commenting that prior to the workshop he visited three hospitals implementing OPQ. He reaffirmed that OPQ responded to the MOH policy and norms for quality through empowerment of local teams and, above all, working as a team. The Vice Minister motivated the hospital team representatives present to continue efforts to improve quality and he committed to seeking the institutionalization of OPQ within the MOH policies.

During the presentations of best practices one thing that stood out was the improvement in the attitude of the health workers to close performance gaps as well as the internal procedures that lead to optimizing the use of resources.

The workshop participants agreed to: 1) Create OPQ teams; 2) Begin by making official notes of the commitments to formalize the process; 3) Begin the follow up visits to expand and transfer the methodology and the use of the data base to the local teams; 4) Begin an accreditation process from the central level; and 5) The participants together with the sub-directors will implement the process within the hospitals with the accompaniment of the central level.

The Project will support similar workshops in Panama, Belize and Costa Rica during the coming year as well as cross-site visits and the dissemination of the OPQ manual.

Hospital OPQ Databases

The measurement databases for all 58 health facilities are completed as well as the functions for including the gap-closing plans and follow up visits. During the first quarter of the coming project year the IT team will design and develop a training plan to transfer the database and how to use it to each of the facilities. The training and transfer will take place during the fourth year's second and third quarters.

➢ Progress in the integration of a gender perspective and human rights within the Project

IntraHealth has begun creating a guide to integrate a gender and human rights focus into the USAID|Capacity Project in Central America. The guide is intended as a reference for Capacity Central America's technical team, hospitals, health centers, universities, and networks within the region on how to integrate and uphold a gender and human rights focus and standards within their institutions, curricula and projects. The guide is being developed based on Capacity's Continuum of Care (CoC) strategy, and integrates the focus within the strategy's components: Promotion & Prevention; Counseling and Testing; Treatment; Clinical Care; and Support Services. This process has developed into a larger effort to fill the gaps regarding knowledge, practice and accessibility of service users, health workers, and the networks we work with in regards to gender, human rights, stigma and discrimination, privilege and oppression, and the core groups of key populations exposed to HIV infection. Materials currently being developed to bridge these gaps include:

- Guidelines for counseling the core groups within the key population exposed to HIV (MSM, Trans, STW)
- Guidelines for training in intersectionality
- Learning activities to facilitate LFP concerning gender and human rights, intersectionality and working with core groups within the key populations.
- Reference and Response system, including:
  - *Geo-referencing map for hospitals, aimed at the general population and adapted especially for the illiterate population.*
  - *Medication control system for PLH, in order to promote adherence.*
  - *Verification flipcharts for counselors,*
  - *Agendas for healthcare workers, networks staff, and service users.*
- Monitoring and Evaluation System with a gender and Human Rights Focus

Next Steps:

Optimizing Performance for Quality (OPQ)

- Provide TA to the MOH and SSI to continue implementing and institutionalizing OPQ, CoC and AMD.
- Transfer OPQ to the central and local levels for their appropriation.
- Hold work meetings on institutionalization of OPQ with local and central level authorities.
- Conclude, validate and disseminate the OPQ manual
- Hold "Champions" meetings and cross-site visits to disseminate best practices.
- Systematize and disseminate lessons learned and successful experiences in each country

Continuum of Care for HIV (CoC)

- Continue dialoguing about the need and benefits of working as a network with different sectors at the central and local levels.
- Strengthen integration of the networks consolidating their common work and objectives to deal with the care of PLH and MARPS.
- Continue optimizing the networks' performance and quality.
- Establish in each country a referral/counter referral system that facilitates continuous comprehensive care leading to improved adherence to ART.
- Update, validate and disseminate the CoC manual in each country.
- Hold meetings and cross-site network visits to transfer best practices and lessons learned.
- Document the experiences in each country to disseminate lessons learned and successful experiences.

In-Service Training

- Develop curricula in nutrition and ART using LFP due to the training gaps in those topics.
- Further strengthen the training teams.
- Assure follow up and accompaniment of trainings for hospitals and CoC networks.
- Assure implementation of training methodologies focused on closing performance gaps.

Pre-Service Training

- Establish new alliances with higher learning institutions to include the HIV curriculum in their course offerings.
- Conclude the HIV curriculum development process delivering the printed materials to the universities
- Participate in MOH working group of all health training institutions in El Salvador to harmonize and strengthen HIV in their training programs.
- Present the HIV curriculum to the Board of Directors of the Nursing School in Costa Rica for implementation in the eight nursing schools there.

- Support the revision of the five public and private training schools for nurses and nurse/auxiliaries in Guatemala to have a standardized HIV curriculum.

Cellular Telephone Technology

- Analyze the results from the follow up post-test of the trial with university students from the VCT courses in Guatemala and El Salvador
- Transfer the mLearning and mHealth experience in accordance with the results of the trial.

Human Resources Information System (HRIS)

- Finalize iHRIS implementation in El Salvador.
- Begin iHRIS implementation in Guatemala and Panama.
- Strengthen the HRIS in Costa Rica.

Systematization and Institutionalization

- Complete the OPQ manual to serve as a practical implementation tool.
- Complete the national OPQ institutionalization plan for sustainability of OPQ contained in the policy framework for quality assurance in at least four countries.

II. ADMINISTRATIVE REPORT

➢ REGISTRATION

IntraHealth International, Inc. has taken the necessary steps to comply with USAID requirements to be legally registered in each of the Project countries. To date, Belize, Costa Rica and Guatemala have met this requirement. In El Salvador, the Project is currently working on reactivating a previous registration done under the PRIME project and is expected to comply with the requirement in 2013.

After evaluating the situation, IntraHealth has determined that registration there is not feasible. Instead, IntraHealth will hire a firm that will handle payroll and in this way will comply with the country's labor and tax laws as well as with USAID requirements.

➢ EMPLOYEE AND CONSULTANT CONTRACTS

According to the Project's new organizational structure and in order to strengthen the regional office team, recruitment and selection processes were put in place to hire professionals who have the skills necessary to fill the following positions:

Monitoring and Evaluation Manager: Roberto Leon is a professional with extensive experience in the management of information and data.

Information Systems Officer for Monitoring and Evaluation: Ricardo Lopez is an expert in information systems, database management and information technology.

Monitoring and Evaluation Officer: Jack Whitehead has extensive experience in data management.

Financial Officer: Aura Marina Hernandez is a business manager with extensive experience in financial and administrative with project partners.

Country Representative Panama: This position was vacant at the end of the Project year. Since then recruitment has been completed and Dr. Joel Mendez will begin on a 90 day trial period beginning in October.

Belize Country Representative: The position is currently vacant; regional staff are carrying out the recruitment and selection process. Plans are to fill this position by the second half of October 2012.

Attached is the current organizational chart which reflects the Project's 14 permanent staff in the regional office and two permanent staff in both Belize and Costa Rica. There are also eight consultants; three in Panama , three in El Salvador, one each in Costa Rica and Belize.

Consultants were also hired to work towards the following results:

- Silvia Flores of Arana is a consultant who specializes in financial administration. She was hired to improve, strengthen, integrate, articulate and systematize current administrative processes and procedures. She also revised and updated the Project's processes, administrative and financial procedures manual so that it was compliant with USAID regulations and IntraHealth policies.
- Dr. Romeo Menendez is an expert in his field and possesses extensive knowledge of the Guatemala health system relevant to his work in support the OPQ strategy.
- Evelyn Boy-Mena is an expert on the topic of gender perspective and human rights, and is fluent in English. She is working as a consultant on Gender and Human Rights.
- In Guatemala two consultants were hired to close gaps in both hospitals and in multi-sectoral networks, particularly in regards to attitudinal factors. Humberto Meza and Oliva Mayra Lopez Rodas were hired to provide training in the field of counseling (pre and post-test), in accordance to the LFP methodology.

RELEVANT ACTIVITIES

In October technical partners and financial administrators traveled to Belize, Costa Rica, El Salvador and Panama to train, supervise and guide country staff on financial, administrative and technical processes. Regional staff took this opportunity to evaluate achievements, goals, and challenges and share success stories from other countries in an effort to strengthen the performance of each. Regional staff also defined the roles and responsibilities for each of the country team members.

In April key project personnel attended a training on the topic of Stigma and Discrimination held by PASMO. Participants learned about PASMO's methodologies, shared experiences between the Projects, and focused on ways to unify efforts in order to achieve the reduction of stigma and discrimination against people living with HIV.

With IntraHealth headquarters support, a Financial Administrative workshop was held in June where topics such as USAID Rules and Regulations and strengthening financial processes were addressed. The workshop was attended by: PASMO; SMCS; and PASCA collaborators; regional and local project partners; and staff from the IntraHealth headquarters office.

In July the Project held a regional workshop in Panajachel, Guatemala, where Country Representatives, IntraHealth headquarters staff, and AOR Lucrecia Castillo participated. During this intensive workshop participants assessed achievements, analyzed possible challenges for the Project's fourth year, and revised the Project work plan. Key activities included sharing lessons learned and successful experiences among country team members.

➢ COST – SHARE

To date, the CAMCAP project has collected USD 1,077,235 in cost-share, which equals 103% of the EOP target set in the Cooperative Agreement. This achievement evidences the commitment and success that each Country Representative had in collecting cost-share. This amount comes from efforts to implement the OPQ strategy through the Ministry of Health (MOH), partner hospitals and the National AIDS Programs.

III. FINANCIAL REPORT

The project executed US$491,262 plus provisional expenditures pending liquidation of US$108,343 during the fourth quarter of Project III for a total of US$599,605 for the quarter and US$1,832,914 for Project Year III ending September, 2012.

The original Year III expenditure projection was $ 1,905,785 with an execution of $1,724,572 (91%) leaving out the provisional expenses. The end of year carryover was $72,870 (1,905,785 - 1,832,914).

USAID|CENTRAL AMERICA CAPACITY PROJECT
BUDGET EXECUTION PROJECT YEAR III (OCT-2011 TO SEPT-2012)

Budget Line Items	Executed (Oct 11-Sept 12)	Regional	Belize	Guatemala	El Salvador	Costa Rica	Panama	Commitments
Comprehensive Care	**$1,285,432**	$581,898	$94,797	$165,229	$135,758	$95,495	$129,347	$82,907
Training	**$118,725**	$0	$23,843	$14,660	$28,425	$26,581	$25,216	$0
Purchases	**$5,573**	$604	$548	$0	$1,374	$1,673	$1,374	$0
Total Direct Costs	**$1,409,729**	**$582,502**	**$119,188**	**$179,889**	**$165,558**	**$123,749**	**$155,937**	**$82,907**
Indirect Costs (30.68%)	**$423,185**	**$174,743**	**$35,511**	**$54,011**	**$49,609**	**$37,116**	**$46,760**	**$25,436**
TOTAL	**$1,832,914**	**$757,245**	**$154,699**	**$233,900**	**$215,167**	**$160,865**	**$202,696**	**$108,343**

IV. CHALLENGES MET AND SOLUTIONS ENCOUNTERED

CHALLENGE	SOLUTION
Changes of MOH/SSI authorities at the central and local levels.	➢ Multiple information presentations at all levels according to the results in the Project agreement. ➢ Presentation of the Project in other forums with government organizations, other cooperation agencies, and possible allies.
Rotation of key decision-making personnel at the central and local levels.	➢ Presentation meetings with the new authorities on Project TA. ➢ Updates and trainings on Project methodologies.
Limited government budgets for gap-closing activities.	➢ Information dissemination and negotiations with other organizations to leverage resources for equipment, supplies and refurbishments of facilities.
Due to the fact that the networks are composed of different government organizations, NGOs and civil society, the consensus-building process has taken longer than anticipated.	➢ Separate visits to individual organizations. ➢ Dissemination of the CoC strategy in public forums. ➢ Incorporation of other organizations such as the security forces, human rights and municipalities.
University closings due to strikes and other activities.	➢ Reprogramming activities and negotiations with other universities.